First Health Services Corporation

Drug Prior Authorization Request Form (MAP-82101, revised 5/15/07)

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

Not to be used for PPI/H2 Blocker, Brand Name, or Atypical Antipsychotic Agents PA requests.
Please use specific forms.

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

SUBMITTED BY : [ ] Prescriber [ ] Pharmacy

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _ _	

First Health is directed to FAX a response to the following fax number (s):	*Prescriber Fax # (Print Clearly)*	*and /or*	*Pharmacy Fax # (Print Clearly)*

	PRESCRIBER Information	PHARMACY Information	
Name			
Phone # *(Not fax number)*			
State License # or NPI *(Not DEA #)*		**NPI #** *(Not DEA #)*	

	Drug Requested (Use separate form to request more than 4 drugs.)	**Dosage Form**	**Strength**	**Quantity**	**Directions for use**	**Start Date for this PA**	**National Drug Code (if known)**
1							
2							
3							
4							

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] Yes [ ] No [ ] Unknown

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION *(including drugs already tried)*_____

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